PRE-ANESTHESIA EVALUATION

Name: _____

Date: _____

Please indicate by a check (✓) your answer to each question.

Your Age:	Height:	Weight:
Planned Operation:		

Have you had or do you still have:	Yes	No	Anesthesiology Dept. Only
Do you smoke, Vapor, Nicotine Patch, etc?			
A cold within past 2 weeks			
Bronchitis, a cough within past 2 weeks ☐			
Pneumonia within past 2 weeks ☐			
Frequent sinus problems			
Emphysema ☐			
Asthma ☐			
Shortness of breath ☐			
Sleep Apnea ☐			
Tuberculosis			
Any other lung trouble			
High or low blood pressure ☐			
Heart Failure ❑			
Stroke ❑			
Heart murmur ☐			
Chest pain, angina ☐			
Heart attack(s) ☐			
Palpitations, irregular or fast heartbeat ☐			
Rheumatic fever			
Anemia ☐			
Sickle cell illness			
Easy bruising, excessive bleeding ☐			
Jaundice, hepatitis, liver trouble			
Back pain or injury			
Slipped disc. Sciatica			
Arthritis, other joint pain			
Convulsions, epilepsy or seizures ☐			
Fainting, blackout spells			
DVT ☐			
Polio, paralysis, meningitis			
Neuro muscular disease ☐			
Thyroid trouble			
Diabetes ☐			
Low blood sugar			
Kidney trouble			
Eye problems			
Infectious diseases (hepatitis, AIDS, MRSA) ☐			
Any other illness not mentioned above:			
Are you allergic to any local anesthetic drugs ☐			
Have you or anyone in your family had an unusual reaction to anesthesia ☐			
Frequent heartburn or Esophageal reflux (Hiatal hernia) ☐			
Post-op Nausea or Vomiting ☐			
List of surgeries you had:			
Have you had or object to blood transfusion			
Do you have any removable dental work, plates, bridges, capped teeth, ☐			
TMJ (Tempro Mandibular Joint) ☐			
Do you drink alcohol			
Are you or could you be pregnant now			
Any serious illness during pregnancy			
Have you had dark or chocolate colored urine			
Elevated temperature after exercise			
Family history of unexplained death after exercise			

List Medications Currently Taking

Medication Allergies:

❑ **None** ❑**Eggs** ❑ **Latex**

Patient/Guardian Signature:

Pre-Op Vital Signs:

BP	P	R	OXY	%	T
EKG					
CXR					
PREG TEST					
ABG		LFS			
PT		PTT		PLAT.	
Hgb		Electrolytes:		Cl	Na
Hct		K		CO^2	
BS		BUN		Creat.	

Remarks: NPO From:

ANESTHESIA PLAN

ASA PS I II III IV V E

General _____Regional _____ Mac_____

Type _____

Risk/Benefit/Option/Discussed with patient or guardian:

Pre-op Ordered:

Date/ Time:

*** B/P_____ P_____ R _____ PO^2_____ T_____ Pregnancy Test Yes No N/A Public Files Rev 2017